

EDITED TASK LISTING

CLASS: HEALTH RECORD TECHNICIAN II (SPECIALIST)

NOTE: Each position within this classification may perform some or all of these tasks.

Task #	Task
1.	Reviews medical records for accuracy and completeness, to provide data for statistical purposes by using various reports (e.g., daily census reports, inpatient/outpatient medical records, etc.), as directed per policies and procedures to comply with State and Federal laws.
2.	Provides detailed coding of medical diagnoses and procedures using standard classification systems [e.g., International Classification of Diseases 9 th Edition Clinical Modification (ICD-9-CM), Current Procedural Terminology (CPT), Diagnostic and Statistical Manual IV (DSM IV), etc.] to provide accurate health data as directed per policies and procedures.
3.	Abstracts information from medical records utilizing medical terminology, medical dictionary, Physicians Desk Reference (PDR), approved abbreviation list, etc. providing diagnostic and treatment information for statistical purposes, as directed per policies and procedures.
4.	Converts medical data collected from census, audits, treatment, etc. into a form for statistical use in data reporting for Health Care Services Division, as directed per policies and procedures to comply with State and Federal laws.
5.	Using the daily patient census, maintains a variety of health record indices for statistical reports on diseases treated, surgery performed, and use of hospital beds as directed per policies and procedures to comply with State and Federal laws.
6.	Prepares various written documents (e.g. memoranda, legal correspondence, reports, etc.) to request and/or provide information to others utilizing communications skills, spelling/grammar, laws, rules and regulations per policies and procedures.
7.	Uses terminal digit filing system to catalog, retrieve and re-file medical records to ensure availability for health care staff per policies and procedures.
8.	Abstracts data, such as demographic characteristics, history, extent of disease, and diagnostic procedures and treatments into the Master Patient Index (MPI) to ensure continuity of patient history per policies and procedures to comply with State and Federal laws.
9.	Gathers pertinent information from medical records, ER logs, hospital daily census reports, etc. to prepare audit reports for use by health care staff, researchers, management and other users per policies and procedures.
10.	Ensure confidentiality in order to protect, control and maintain the integrity of the medical record by using implemented policies and procedures to comply with State and Federal laws.
11.	Update existing medical records to accommodate new or different information and to provide complete and current patient information per policies and procedures.
12.	Assemble discharged patient record using standardized organizational guidelines, ensuring each document has appropriate patient identifiers to produce an accurate patient record, per policies and procedures.
13.	Receives and/or directs a variety of telephone calls providing appropriate information to visitors and staff per policies and procedures.

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14.	Process and reproduce correspondence for the patient, third parties, and community facilities, assuring information is released in accordance with State and Federal laws.
15.	Conduct medical record interviews in response to patient requests for review and/or copies of personal medical records, per policies and procedures in accordance with State and Federal laws.
16.	Process subpoenas and court orders to produce copies of medical records for litigation purposes per policies and procedures in accordance with State and Federal laws.
17.	Process death records for review of morbidity and mortality reporting per policies and procedures in accordance with State and Federal laws.
18.	Perform various quality reviews, using concurrent and retrospective methodology to ensure compliance with internal and external requirements per policies and procedures in accordance with State and Federal laws.
19.	Maintain various logs (medicolegal, death, incomplete inpatient records, discharge, equipment, etc.) for statistics, substantiation and accountability in order to provide quality health care per policies and procedures in accordance with State and Federal laws.